

Identifying the Community's Critical Health Issues

Relevant H2P2 Outcomes

Armed with its working community description, the SAC members can now begin to compare their community's health characteristics with the guidelines from the H2P2 outcomes. Where the local data is sketchy or missing altogether for the community, the SAC may find some guidance by using statewide data as estimates, or by looking at national efforts such as *Healthy People 2010* for data in the areas of concern that are comparable to those in the H2P2. (NOTE: Summaries of the H2P2 outcomes and the *Healthy People 2010* objectives may be found in sections I.C and I.D of this workbook. The complete text of *Healthy People 2010* may be found on the World Wide Web: <http://www.health.gov/healthypeople/>.)

In this review of the outcomes, the SAC members will be looking primarily for those areas where their community compares less favorably to either state or national data in a particular disease or condition of concern. The SAC members may also want to make note of those areas in which their community shows a higher degree of risk factors for a disease or condition of concern. Risk factors are those aspects of a person or group and the environment or personal experience that make it more likely that people will experience a given disease or condition of concern. Risk factors may be personal factors, such as an individual's knowledge and skill, experience and history, and genetic makeup. Risk factors may also be environmental factors, such as support and services; access, barriers, and opportunities; consequences of efforts; and policies and living conditions.¹ There may be occasions when the community does not show unfavorable rates of disease, but it does show unfavorable rates of risk factors for a disease. Such a situation may become a target for a health improvement initiative.

Community Perceptions

While quantitative data are necessary, they are not sufficient to tell the whole story when it comes to picking a health target for improvement. The likelihood of success in a particular initiative is greatly enhanced when the initiative is "owned" by the community—i.e., community members (not just health professionals) feel it is something they care about, and that they had an integral part in selecting the approach and planning its implementation. Those who work in promoting performance and results accountability advise starting where people are passionate, and where it feels right for one's county, city or community. Outsiders should not be the ones telling the community where to start.² Still others have noted that if a problem is of sufficient concern, even small numbers of cases (e.g., drug-resistant tuberculosis or teen suicides) may be enough to motivate a community to respond.³

The SAC members may already have a relatively clear sense of what the community's greatest health worries are from their work in developing the community description. However, it still may be worthwhile to bring in community members to a listening session or focus group⁴ to further explore the H2P2 concerns and find where the passion

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lies. Community preference, along with the likelihood of early success, should be the driving force in the selection process. The best thing may be, in fact, to address an issue even if it is not seen by all as the “most important” one.⁵ (***Outline for Naming the Issue/Problem/Goal to Be Addressed*** in the “Tools” section offers one approach to “naming” the problem.)

Picking the Curve to Turn

By now, the SAC members will probably have a reasonably clear notion of what the H2P2-related health issues are for their region and what the community preferences and priorities are. This is the point where applying “results-based decision making” will help the SAC members start moving from “talk to action on results.” Here the SAC members will be identifying the population of concern, adopting a working list of results and indicators, and picking the curve to turn.⁶ (***Results-Based Decision Making: Getting from Talk to Action*** in the “Tools” section depicts the full decision making framework.)

What is the Population of Concern? The first step is to identify the population or subpopulation that the SAC and its community are concerned about. This population may be defined by geography or by both characteristics and geography. “All children in the county,” “all elders in the state,” and “all citizens in the community” are examples of populations defined by geography. “All school-age children with disabilities in the county,” “all frail elders over age 85 in the state,” and “all families with children in the community” are examples populations defined by characteristic and geography. Examples of subpopulations include “all children from a particular ethnic or cultural group,” or “all children 0 to 5.” The results-based decision making process applies universally to all of these groups. One thing to keep in mind, however, is that as the group gets smaller and smaller it becomes harder to get reliable timely data to use as indicators. It is important also to understand that there are many different populations for which results can be developed, and there is no standard set of results.⁷ (***The Subpopulation View of Results*** in the “Tools” section illustrates the relationship of subpopulations to populations.)

What are the Desired Results? Results-based decision making is about the well being of a population or subpopulation across a given geographic area (as opposed to the client population of a particular program, agency or service system). As used here, results are “plain language conditions of well-being for children, adults, families and communities.” Well-being can be intellectual, social, emotional and/or physical.

Results for the population of interest are identified by asking the questions:

- What do we want for these people?
- What do they want for themselves?

Generally, answers to these questions will be phrases such as “Children (elders) who are (safe, healthy, etc.).” The goal is to develop a set of condition statements that the public will understand, that say something important about the well-being of the given population, and which are reasonably complete. Results statements are related to ends, not means—i.e., they are not statements about data or about services.

To complete this step, the SAC will want to develop a list of candidate results. This is a brainstorming process in which all ideas are acceptable as long as they are not “data” and are “ends,” not “means.” The list will likely be rough, with overlapping statements, but these can be refined to create a balanced and complete set of results statements in plain language.

A note of caution: starting on one result without a complete list of results can lead to a skewed product that views the world through the eyes of just one agency or profession. A more credible product will come from developing a complete working list of results before choosing the one to work on. It is also important to avoid imposing on local folks a set of results developed at the state level. The selection process needs to be respectful of the legitimate differences existing between state and local conditions, values and priorities. When the SAC members are satisfied that their working list is sufficiently complete and representative of the community, then they will select the result(s) they wish to target for the next stage of the process.⁸

What are the Indicators (Experience) of the Results? Indicators are what we use to measure the achievement of the results that we desire. (***Choosing a Common Language*** in the “Tools” section shows the relationship of indicators to results as well as some of the other terms commonly used.) Indicators answer the question “How would we recognize these results in measurable terms if we fell over them?” (***The Difference between the Role of Indicators and the Role of Performance Measures*** in the “Tools” section may help clarify the difference between an indicator and a performance measure.)

The first step in identifying indicators is to develop or articulate an experiential version of a result. Each experience is a pointer to a potential indicator. To do this, ask the questions:

- How would you experience (e.g., healthy children) in day-to-day life?
- What would you see, hear, feel, and observe as you walked around the community?

Brainstorm a list of experiences for each result that is of interest to the SAC. The goal here is to include only experience statements, not actual indicators themselves or strategy ideas. Examples of these differences are shown below for the result “Children Ready for School”:

- I would see children playing well on the playground. (Experience)
- The young children I meet would know their ABCs. (Experience)
- The percent of children promoted from kindergarten to first grade. (Indicator)
- Every child who needs child care would get it. (Strategy/What works)

Identifying these experiences has value in that it not only helps to ground the result in everyday experience, but also is another way to connect with partners, such as parents, youth, businesspeople, faith community members, and the like, who are put off by jargon and exclusionary language. Experiential versions of results can be used to steer the planning process when there is no good data available. (***Some ways we experience***

Children Healthy and Ready for School in the “Tools” section illustrates experiences for a result.)

Once the experiences of the result(s) have been stated and agreed upon, the work of selecting the indicators begins. The SAC members and their work group can start by brainstorming a list of possible indicators for their experience statements. These indicators are data statements—e.g., the % of children fully immunized by age 2. Some indicator statements can be found in the outcome measures of *H2P2*, and there may be other sources available as well from community initiatives or report cards (e.g., the “Kids Count” or “Health Trends in Hawaii” reports). Key informants from the SAC’s earlier community description work may be helpful here, particularly those who are in the academic community. (***Examples of Community-Level Indicators*** in the “Tools” section provides some suggestions in five different areas of concern.)

When the list of potential indicators is complete, then each indicator will be rated using three section criteria to pick the best ones to represent the result:

- **Communication Power.** Does the indicator communicate to a broad range of audiences? If you had to explain what the result means to your neighbors (being in the public square), what two or three pieces of data would you use. They must be common sense, not arcane and bureaucratic. To have communication power, data must have clarity with diverse audiences.
- **Proxy Power.** Does the indicator say something of central importance about the result, or is it peripheral to the result? Can this measure stand as a proxy for the plain English statement of well-being? What pieces of data really get at the heart of the matter? Indicators run in herds—if one is going in the right direction, often others are as well. Since you don’t want 20 indicators telling you the same thing, select the ones that are most likely to match the direction of other indicators in the “herd.”
- **Data Power.** Do we have quality data on a timely basis? Data should be reliable and consistent. And it should be timely so that one can see progress—or lack thereof—on a regular and frequent basis. When there are problems with data availability, quality or timeliness, a data development agenda can be used to address these over time.

(***Choosing Indicators Worksheet*** in the “Tools” section can help organize the rating process.)

One way to narrow the choices of indicators is to look for “headline measures”—those indicators for which there is “good” data. This means that decent data is available today, or could be produced with little effort. Mark each one of these indicators on the worksheet. Then ask, “If I had to talk about the result in a public place, which one would it be?” Put a star by the answer. Then ask, “If I could have a second measure...and a third?” Identify no more than 4 or 5 measures, and mark these on the worksheet. These choices represent a working list of headline measures for the result. Likewise, use a similar process to produce a data development agenda. Ask, “If I could buy one of the measures for which we don’t have data, which one would it be?” Mark that indicator. Then ask, “If I could buy a second measure...and a third?” List 4 or 5 measures, which

now become your data development agenda, in order of priority. (*The Contra Costa County Children's Report Card 2000* in the “Tools” section is an example of results and indicators.)

One note of caution: make sure the indicators do not include targets—e.g., teen pregnancies will decrease to no more than 5 per 1000 births. These are called “compound indicators,” and make it much more difficult to set the target in relation to the baseline, which will change over time.⁹

Where We've Been/Where We're Headed. Now that the indicators of choice have been identified, it is time to take stock of what the trends have been, and are likely to be for each of the indicators. Tracking how often things happen, and the duration and intensity of most incidents helps establish the baseline, or standard against which the SAC will measure all subsequent changes implemented by its health improvement initiative.

Baseline measures can tell you whether your efforts are working or can help you make sense about something that might be too large and complicated to understand otherwise. Baselines can also help you determine whether this is a good time to start an intervention, or whether a particular intervention is appropriate, or if an intervention is even necessary. To begin establishing the baselines for chosen indicators, the SAC members will need to decide exactly what they are going to measure, and for how long. A good baseline will include information gathered at several points over a period of time, rather than simply a snapshot of information gathered over a short time span, such as a weekend. Based on the data, the SAC members can decide what problem(s) should most be addressed by its efforts.

Baselines have two parts: an historical part which shows where you've been and a forecast part that shows where you're headed if you stay on your current course. Baselines allow you to define success as doing better than the baseline or “turning the curve.” Baselines allow you to ask and answer the question: “Is this future OK?” If a positive behavior has been declining for several years, “Is it OK for it to continue to decline? Look at where we'll be in two years if this continues!” Most processes of serious change start with members of the community saying, “This is not OK. We can do better.”

Baselines also allow you to assess progress in terms of “doing better than the baseline.” It allows you to count it as progress when the rate at which things are getting worse has slowed, before it fully turns around and goes in the right direction. It takes time to turn the curve on such a trend line. If success is not measured through baselines, then there may be a setup for failure by creating unrealistic expectations of quick fixes.

The hard part of baselines is forecasting the future. The best forecasting is not about technical statistical analysis. Rather it involves people who know “what's happening on the street” and who can create two or three believable scenarios of the likely future. Forecasts should reflect the consensus view of key partners about where things are headed.

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A simple way to organize a discussion of forecast is to ask the following questions, and at each step ask “why”:

- Do we think the trend will continue in the same direction?
- Will it go in that direction faster, slower or about the same?
- Do we think the trend will flatten out? When will it flatten out and at what level?
- Do we think the trend will change direction? When? What will happen after?¹⁰

(Process for Creating Baselines from Group Knowledge and Consensus in the “Tools” section illustrates this technique.)

Where Will We Start? Based on the baselines data, the SAC members can now decide what indicator(s) should be addressed through a health improvement initiative. What looks like it most needs to be dealt with? Is it something the SAC and its partners can reasonably expect to be able to change?¹¹ The SAC’s choice(s) here will become the “critical health issue” with which the members will move into the “analysis and implementation” phase in their journey to “turn the curve.”

Tools for this section: *Outline for Naming the Issue/Problem/Goal to Be Addressed, Results-Based Decision Making: Getting from Talk to Action, The Subpopulation View of Results, Choosing a Common Language, The Difference between the Role of Indicators and the Role of Performance Measures, Some ways we experience Children Healthy and Ready for School, Examples of Community-Level Indicators, Choosing Indicators Worksheet, The Contra Costa County Children's Report Card 2000, Process for Creating Baselines from Group Knowledge and Consensus*

Notes

¹ Adapted from KU Work Group on Health Promotion and Community Development (2000). Chapter 19, Section 2: Understanding Risk and Protective Factors: Their Use in Selecting Potential Targets and Promising Strategies for Interventions. Lawrence, KS: University of Kansas. Retrieved 8/21/2002 from the World Wide Web: http://ctb.ukans.edu/tools/EN/sub_section_main_1156.htm

² Adapted from “Where do we start?” in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 8/25/2002 from the World Wide Web: <http://www.raguide.org>

³ Chapter 4, “A Community Health Improvement Process,” in Improving Health in the Community: A Role for Performance Monitoring, JS Durch, LA Bailey, MA Stoto, eds., National Academy Press, Washington, D.C., 1997, pp. 93-103. Retrieved 7/2/2002 from the World Wide Web: <http://www.nap.edu/openbook/0309055342/html/>

⁴ See the “Questions for a Focus (or Listening) Group” tool in Section I.E.2 of this workbook.

⁵ Chapter 4, “A Community Health Improvement Process,” in Improving Health in the Community: A Role for Performance Monitoring, op. cit.

⁶ Adapted from “Where do we start?” in M. Friedman, The Results and Performance Accountability Implementation Guide, op. cit.

⁷ Adapted from “What are some populations for which results can be developed and used?” in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 8/25/2002 from the World Wide Web: <http://www.raguide.org>

⁸ Discussion of results adapted from “Turn the Curve Exercise,” “What is the difference between population well-being (results accountability) and client well-being (performance accountability) and why is it important?” and “How do we select results for a given population?” in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 7/12/2002 from the World Wide Web: <http://www.raguide.org>

⁹ Discussion of experience and indicators adapted from “How do we identify resulting in terms of everyday experience?” in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 7/12/2002 from the World Wide Web: <http://www.raguide.org> and “How do we select indicators for a result?” in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 8/25/2002 from the World Wide Web: <http://www.raguide.org>

¹⁰ Discussion of baselines adapted from KU Work Group on Health Promotion and Community Development (2000). Chapter 3, Section 9: Developing Baseline Measures of Behavior. Lawrence, KS: University of Kansas. Retrieved 9/24/2002 from the Wide World Web: http://ctb.ukans.edu/tools/EN/sub_section_main_1044.htm, and “How do we create a baseline (trend line) for an indicator?” in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 7/27/2002 from the World Wide Web: <http://www.raguide.org>

¹¹ Adapted from KU Work Group on Health Promotion and Community Development (2000). Chapter 3, Section 9: Developing Baseline Measures of Behavior, op cit.

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Tools

Outline for Naming the Issue/Problem/Goal to Be Addressed*

1. Justify the priority issue(s)/problem(s)/goal(s) to be addressed - Questions helpful in justifying choice of a priority issue include:
 - a. How often does the issue/problem occur?
 - b. How many people are affected?
 - c. For what amount of time are they affected?
 - d. How severe (significant) is the effect?
 - e. How important is the problem/goal perceived to be by others?
 - f. How effective are efforts likely to be?
 - g. Any negative impacts of addressing the problem/goal?
2. State the issue/problem/goal to be addressed
 - a. Label the condition that is at the root of the community issue/problem/goal.
 - b. Frame as either:
 - (1) Lack of/too few of a POSITIVE condition (e.g., more kids should graduate from high school; all should be safe in their neighborhoods)
 - (2) Presence of/too much of a NEGATIVE condition (e.g., too many kids drop out of high school; there is too much violence)
 - (3) Or both (if different constituencies seem to respond to different framing).
3. Review the naming and framing of the issue/problem/goal
 - a. Does the statement of the issue focus on the condition or outcome of interest? (E.g., school success and/or dropouts; safety and/or violence)?
 - b. Does it avoid defining the issue/problem in terms of a preferred solution?
 - c. Is issue/problem/goal framed in a way to build consensus?

* Adapted from Community Tool Box, <http://ctb.ukans.edu/>.

Results-Based Decision Making

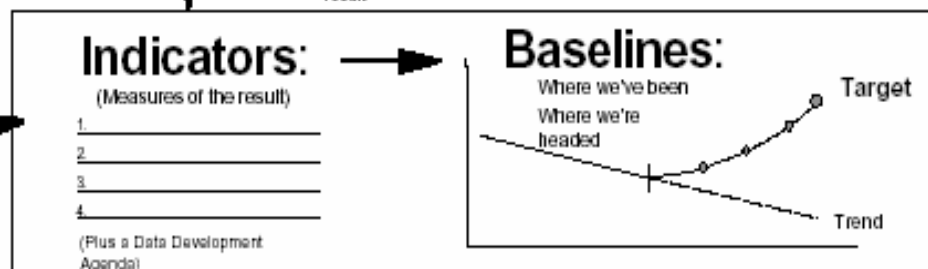
Getting from Talk to Action

Population: e.g. Children prenatal to age 5



Result: e.g. Children enter school healthy and ready to learn

What we want for children in plain English, plain Spanish...
Plus how we "experience" the result



Plus a Cost of Bad Results Analysis

Story behind the baselines:

The causes, the forces at work; the epidemiology of the baselines
(plus information/research agenda part 1)

Partners with a role to play:

Public and private sector agencies and individuals

What works

What would it take to turn the curve in this community, best practices, best hunches
(plus information research agenda part 2)

Criteria

Could include:

Specificity: clear who, what, when, where, how
Leverage: power to turn the curve
Values: consistent with community values
Reach: feasible, affordable

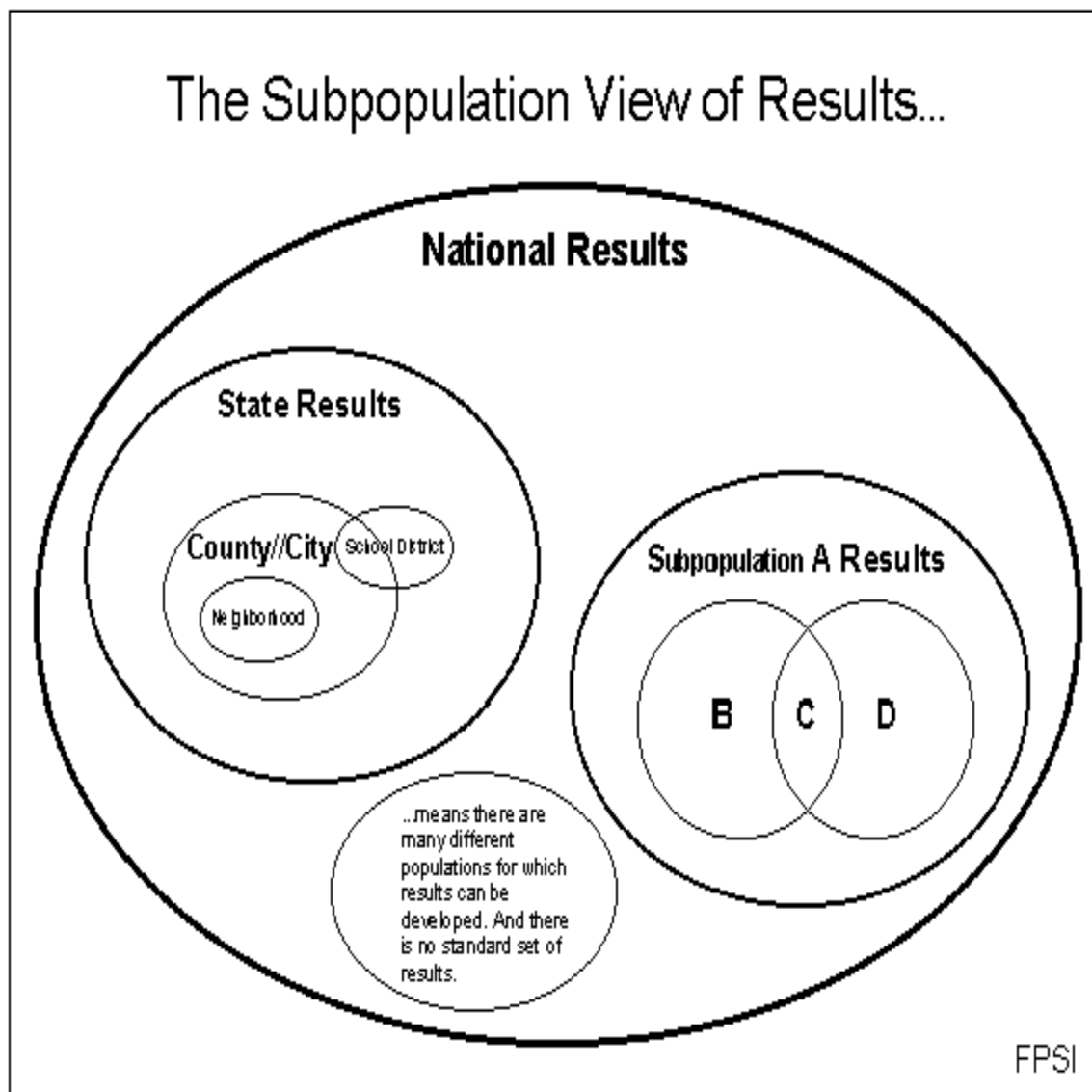
Action Plan and Budget

What we propose to do: multi-year action plan and budget
How the "what works" pieces fit together in a community system of services and supports

Performance Measures: Measures of how well programs, services, supports, agencies and service systems, included in the action plan, are working

FPSI

"The Whole Distance from Results to What Works Exercise," in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 7/12/2002 from the World Wide Web: <http://www.raguide.org>. Used by permission.



“What are some populations for which results can be developed and used?” in M. Friedman, [The Results and Performance Accountability Implementation Guide](#), Fiscal Policies Studies Institute, 2002. Retrieved 8/25/2002 from the World Wide Web: <http://www.raguide.org> Used by permission.

CHOOSING A COMMON LANGUAGE Discipline vs. The Tower of Babel		
Column A	Column B	Column C
A condition of well-being for children, adults, families or communities	A measure which helps quantify the achievement of (Column A)	A measure of how well agency or program service delivery is working
<hr/>	<hr/>	<hr/>
Choose One: 1. Result 2. Outcome 3. Goal 4. Other	Choose One: 1. Indicator 2. Benchmark 3. Milestone 4. Other	Choose One: 1. Performance measure 2. Program measure 3. Other

From "How do we fit together different approaches when there is more than one approach to results and performance accountability being used in my area?" in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 7/12/2002 from the World Wide Web: <http://www.raguide.org> Used by permission.

**The Difference between the Role of Indicators
and the Role of Performance Measures**

Indicators are about <u>whole</u> populations.	Performance measures are about <u>client</u> populations.
Indicators are usually about people's lives, whether or not they receive any service.	Performance measures are usually about people who receive service.
Indicators are proxies for the well-being of whole populations, and necessarily matters of approximation and compromise.	Performance measures are about a known group of people who get service and conditions for this group can often be accurately measured.

From "How do we get people to understand the difference between indicators and performance measures?" in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 7/12/2002 from the World Wide Web: <http://www.raguide.org> Used by permission.

Some ways we experience
Children Healthy and Ready for School

- Enthusiastic about going to school
- Dressed appropriately for the season
- Familiar with letters and numbers
- Does not experience violence
- Interacts appropriately with peers
- Shows social interaction skills on the playground
- Hygienic in bedroom and bathroom
- Well nourished
- Coordinated fine and gross motor skills
- Parental enthusiasm
- Positive self image
- Able to communicate

Adapted from “How do we identify results in terms of everyday experience?” in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 7/12/2002 from the World Wide Web: <http://www.raguide.org>

Examples of Community-Level Indicators*

Example # 1: Recommended Community-Level Indicators for Substance Abuse Coalitions

1. Number of single-car nighttime vehicle accidents.
2. Number of drug positives from urine samples of arrested people.
3. Number of arrests for drug possession.
4. Cost and purity of street drugs.
5. Number of drug positives from urine samples of pregnant women at the time of delivery.
6. Number of alcohol or drug (AOD)-related emergency room episodes.
7. Number of AOD-related deaths.
8. Number of individuals on waiting lists for and admissions to in-patient and out-patient AOD program service.
9. Number of referrals and admissions to mental health centers for AOD problems.
10. Incidence of AOD-related birth outcomes (e.g., fetal alcohol syndrome, positive drug toxicology).
11. Incidence of drug-related sexually transmitted diseases (STDs), including HIV transmission in AIDS cases.
12. Incidence of AOD-related medical conditions (e.g., cirrhosis of the liver, hepatitis).
13. Number of drug positives from urine samples of job applicants and employees.
14. Aggregate per capita consumption of alcohol, based on alcohol tax revenue data.

Example # 2: More Recommended Community-Level Indicators for Substance Abuse Coalitions

1. Drug-affected babies.
2. Student alcohol and drug abuse.
3. Juvenile arrests for drug offenses.
4. Adult arrests for drug offenses.
5. Arrested people testing positive for drugs.
6. Marijuana plants seized.
7. Positives in pre-employment drug testing.
8. Employees with employee assistance programs.
9. People treated for substance abuse problems.
10. Teen alcohol-involved traffic deaths.
11. Adult alcohol-involved traffic deaths.
12. Drug overdose deaths.

* Adapted from Community Tool Box, <http://ctb.ukans.edu/>

Examples of Community-Level Indicators (Continued)

Example # 3: Recommended community-level indicators for adolescent pregnancy prevention initiatives

The estimated pregnancy rate for females aged 15-19 is the most commonly used indicator for adolescent pregnancy. Data may also be available for females ages 10-19 and 10-14. Currently, the majority of the pregnancies occur within the 15 to 19 year old age group.

Technical Notes

The formula for calculating the estimated pregnancy rate is as follows: (live births + fetal deaths + reported abortion) / population of females age 15-19 x 1000.) This formula can also be used to calculate the estimated pregnancy rate for females of different ages. Epidemiological data such as these rely on the accuracy of both the numerator and denominator. Limitations of each are described below.

Abortion data include only those reported by hospitals and clinics participating in state health department report systems. Because of their sensitivity, abortion data tend to be underreported. For example, in a typical county in 1993, 6.6% of adolescent pregnancies reportedly resulted in an abortion. Yet, nationally, it is estimated that 36% of adolescent pregnancies result in abortions.

Population estimates for the age group may come from different sources. Estimates are available from the Census Bureau and as well as from state offices such as health departments and university research institutes. Population estimates may come from different sources over a given time period. For example, population estimates for years 1 through 5 may have been provided by the state Census Bureau and for years 6 through 10 by a local research institute.

It is important to know the data that are needed to compute the estimated pregnancy rate for a given age group and their limitations. Because of the difficulty in securing data on abortions and population size with absolute certainty, the estimated pregnancy rate for adolescents age 15 through 19 remains an "estimate." Issues around reporting by hospitals in a given area and the accuracy of recording place of residence of the mother may also come into play when exploring the accuracy of estimated pregnancy rate as an indicator. Changes in data collection that may have occurred over the period of the prevention initiative, and a few years prior, should also be explored with the state health department's statistician. This way, you can give the initiative a sense of whether changes in the estimated pregnancy rate could be due to a change in reporting rather than as a result of the initiative.

Example # 4: Recommended Community-Level Indicators for Tobacco Control Initiatives

- Per capita consumption of tobacco products

Examples of Community-Level Indicators (Continued)

Note: This represents the most objective data available on population levels of tobacco consumption. Data are available from the state health department (or department of revenue) based on the excise taxes that are imposed on tobacco products. Excise taxes are collected at the level of tobacco distributors. This information is available on a monthly basis.

Variability from month to month may be an artifact of this measure. It may reflect patterns of stocking at the retail level. When systematic seasonal variations are adjusted for, however, collective sales data provide the best available estimate of total tobacco use.

The main limitation of these data is that they do not provide information on the behavior of consumers. A change in consumption rate is a composite of many individuals' uptake and quitting behavior. For example, a drop in cigarette sales may be the result of the same people smoking fewer cigarettes or fewer people smoking. Nor do consumption data indicate what changes in special populations, such as young women or ethnic minorities, might be reflected in the data. Despite these limitations, tobacco consumption remains the best community-level indicator.

Example # 5: Recommended Community-Level Indicators for Injury Control Initiatives

1. Deaths due to unintentional injuries.
2. Hospitalizations due to unintentional injury.
3. Deaths caused by motor vehicle crashes.
4. Deaths from falls and fall-related injuries.
5. Drowning deaths.
6. Hip fractures among older adults.
7. Emergency room admission for non-fatal poisonings.
8. Hospitalizations due to non-fatal head injuries.
9. Hospitalizations due to non-fatal spinal injuries.
10. Secondary injuries associated with injuries to the head and spinal cord.
11. Deaths due to farm-related injuries.
12. Hospitalizations due to farm-related injuries.
13. Local sources of other measures may include coroner and police reports, data from walk-in clinics and emergency rooms, child care centers, schools, nursing homes, social service agencies, senior services, large businesses, and insurance companies.

Example # 6: Recommended Community-Level Indicators for Violence Prevention Initiatives

1. Uniform Crime Reports, Federal Bureau of Investigation / Department of Justice: Published annually; includes crimes such as rape, assault, homicide, and robbery.
2. National Crime Survey and National Victimization Survey: Administered annually; includes questions about spouse, child and elder abuse.

Examples of Community-Level Indicators (Continued)

3. National Center for Health Statistics Mortality Data and Centers for Disease Control Mortality Data (Center for Disease Control and Prevention, Atlanta, GA): Includes data collected based on the ninth edition of the international Classification of Diseases; summarize the deaths in the United States by cause and demographics.
4. State Crime Data (for example, from the Kansas Bureau of Investigation): Published annually; includes the same information given to the FBI for their Uniform Crime Reports, but is broken down by county and metropolitan areas.
5. State Incident Based Reporting System (for example, from the Kansas Bureau of Investigation): Unpublished data; includes information provided by police agencies through "Standard Offense Reports" and "Standard Arrest Reports."
6. State Juvenile Justice Information System (for example, from the Kansas Bureau of Investigation): Unpublished data; includes the same information provided by the Incident Based Reporting System as well as information from Child in Need of Care or Child in Need of Services reporting.
7. Local sources of data may include coroner reports and local police reports, information collected by the school district on the incidence and prevalence of assaults, and information collected by local women's shelters and social service agencies about spouse abuse.

Choosing Indicators Worksheet*

Outcome or Result _____

Criteria for Choosing Indicators As Primary vs. Secondary Measures

Communication Power: Does the indicator communicate to a broad range of audiences?

Proxy Power: Does the indicator say something about the result? Does the indicator bring along the rest of the data "herd"?

Data Power: Is quality data available on a timely basis?

Candidate Indicators	Communication Power	Proxy Power	Data Power

*Adapted from "How do we select indicators for a result?" in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 8/25/2002 from the World Wide Web: <http://www.raguide.org>

The Contra Costa County Children's Report Card 2000

Children ready for and succeeding in school

Toddler immunizations
High School Dropouts

Children and youth healthy and preparing for productive adulthood

Births to Adolescent Girls
Juveniles Committing Violent Crimes
Alcohol and Drug Use
Sexually Transmitted Diseases
Low and Very Low Birth Weight Babies

Families that are economically self-sufficient.

Income and Unemployment
Free and Reduced Price School Lunches
Child Care Availability and Affordability

Families that are safe, stable and nurturing.

Timely Prenatal Care
Homeless Families
Children in Foster Care
Domestic Violence

Communities that are safe and provide a high quality of life.

Injuries to Children and Youth
Alcohol-Related Traffic Collisions
Infant Mortality
Adolescent Tobacco use

Children and Families Policy Forum, [The Contra Costa County Children's Report Card 2000](http://www.cccoe.k12.ca.us/bout/reptcard.htm), Contra Costa County Office of Education, Pleasant Hill, CA. Retrieved 10/12/2002 from the World Wide Web:
<http://www.cccoe.k12.ca.us/bout/reptcard.htm>.

Process for Creating Indicator Baselines Using Group Knowledge and Consensus

A. For each indicator ask:

1. What is the current status: Good or Bad?
2. Has this been getting: Better, Worse, Staying the same?
3. Optional: Is it getting (better or worse): Fast or Slow?

B. This will produce a worksheet something like this:

G ↑ s	Indicator 1	
G ↓ s	Indicator 2	
B ↑ s	Indicator 3	
B ↓ s	Indicator 4	<div>Possible top priorities for action</div>
G ↔	Indicator 5	
G ↓ f	Indicator 6	
B ↔	Indicator 7	
B ↓ f	Indicator 8	

C. Which then allows individual indicator curves (with forecasts developed using the same technique) to be depicted on a line graph as the starting point for work on turning the curve. (Indicators without data should be added to the Data Development Agenda.) FPSI

From "How do we create a baseline (trend line) for an indicator?" in M. Friedman, The Results and Performance Accountability Implementation Guide, Fiscal Policies Studies Institute, 2002. Retrieved 7/12/2002 from the World Wide Web: <http://www.raguide.org> Used by permission.